Using Information To Improve Patient Flow

Ward Discovery Phase

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Daisy Hill Hospital Site

Background

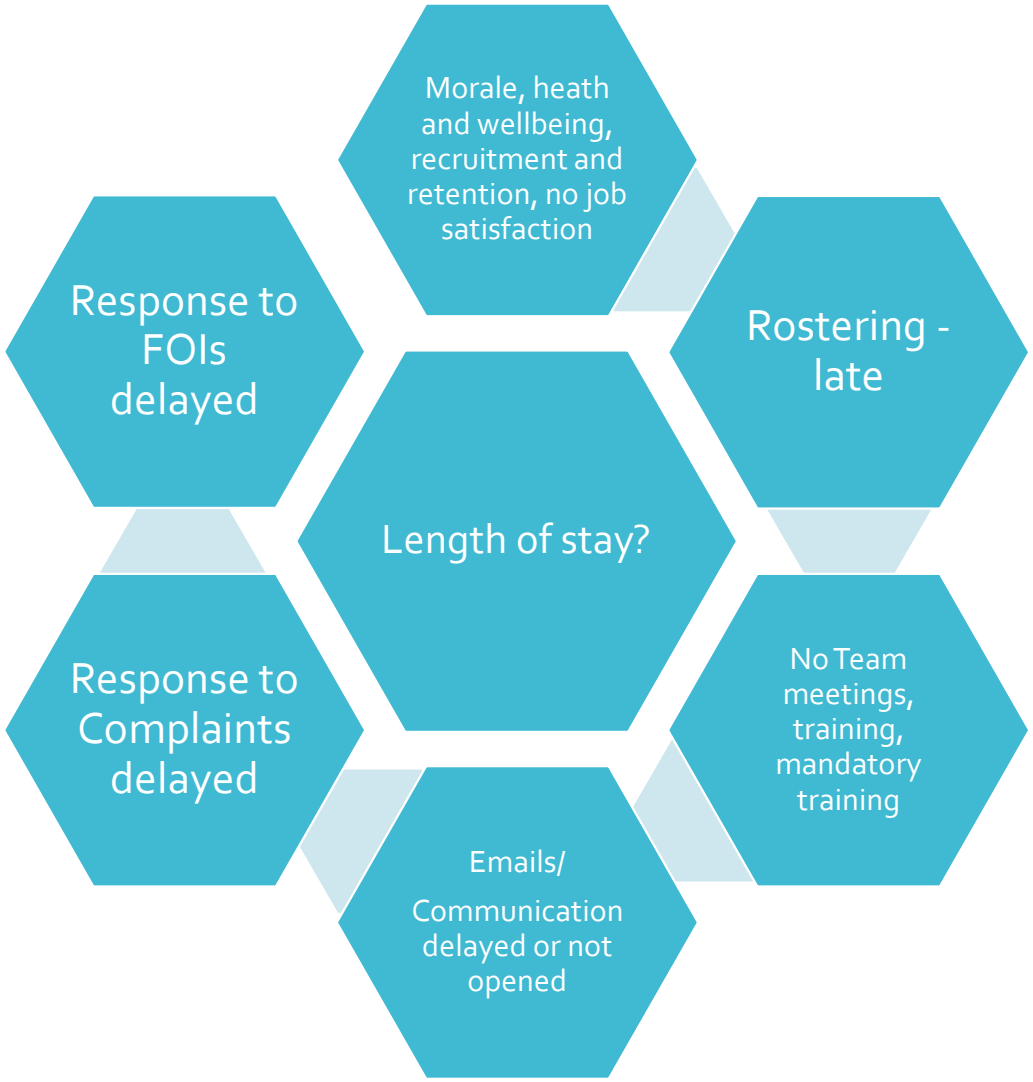
- Reducing Length of Stay Paper November 2022
- Reasons for increasing LOS unclear
- Can provision of timely, useful data help wards improve patient flow and reduce LOS?
- Phase 1 – meeting with each MUSC ward MDT's in CAH & DHH as the 'discovery phase'

MDT Feedback

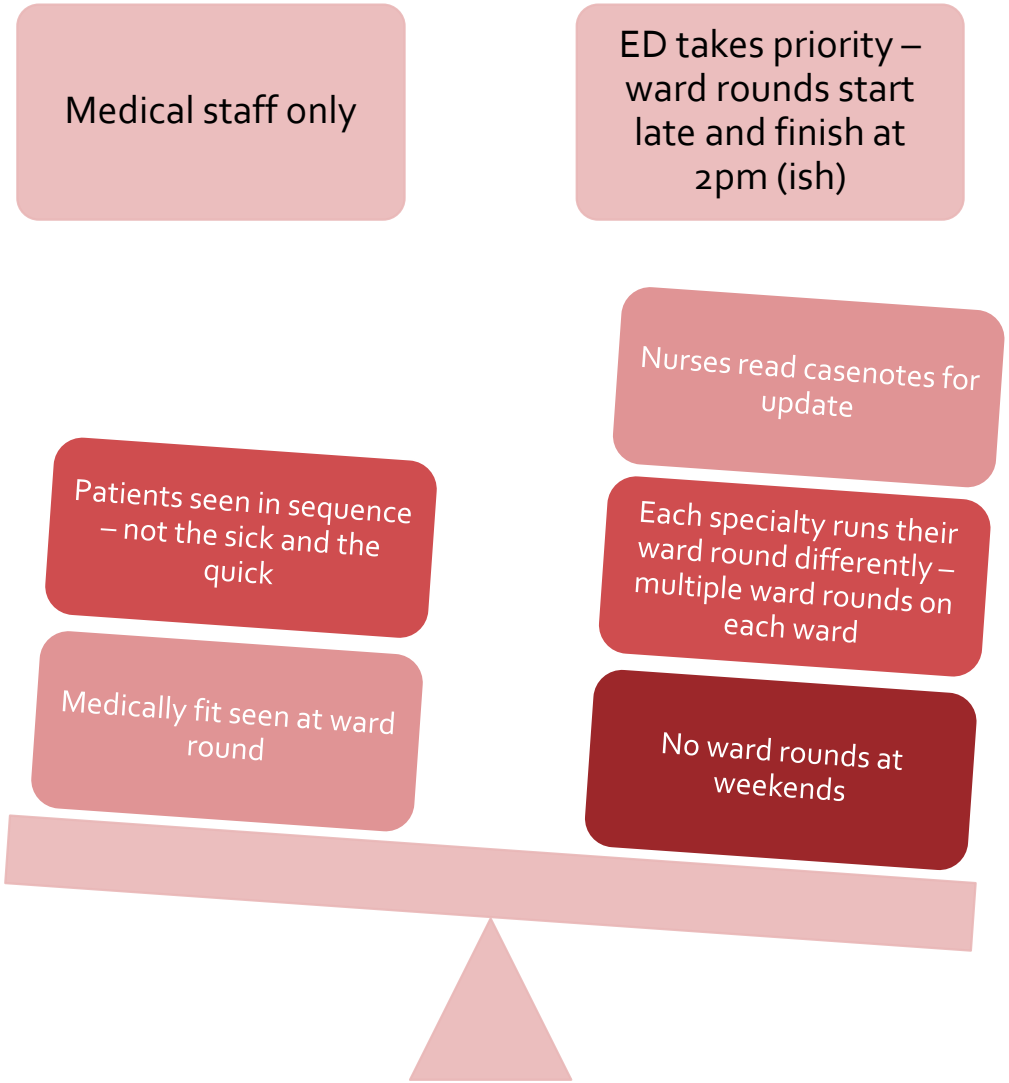
Daisy Hill Hospital MUSC Ward

Everyone's Focus is on Discharge

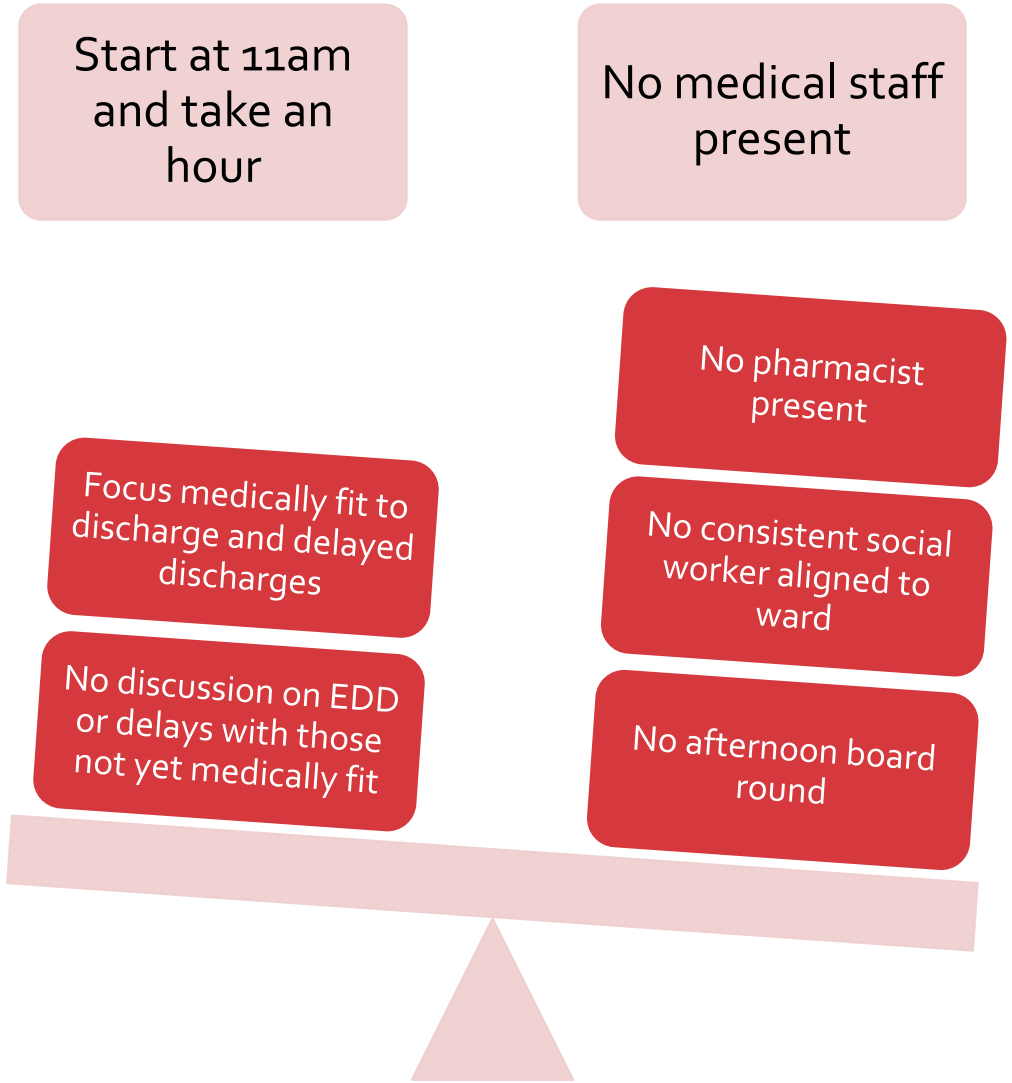
As a result of this focus on discharge – what is the impact?



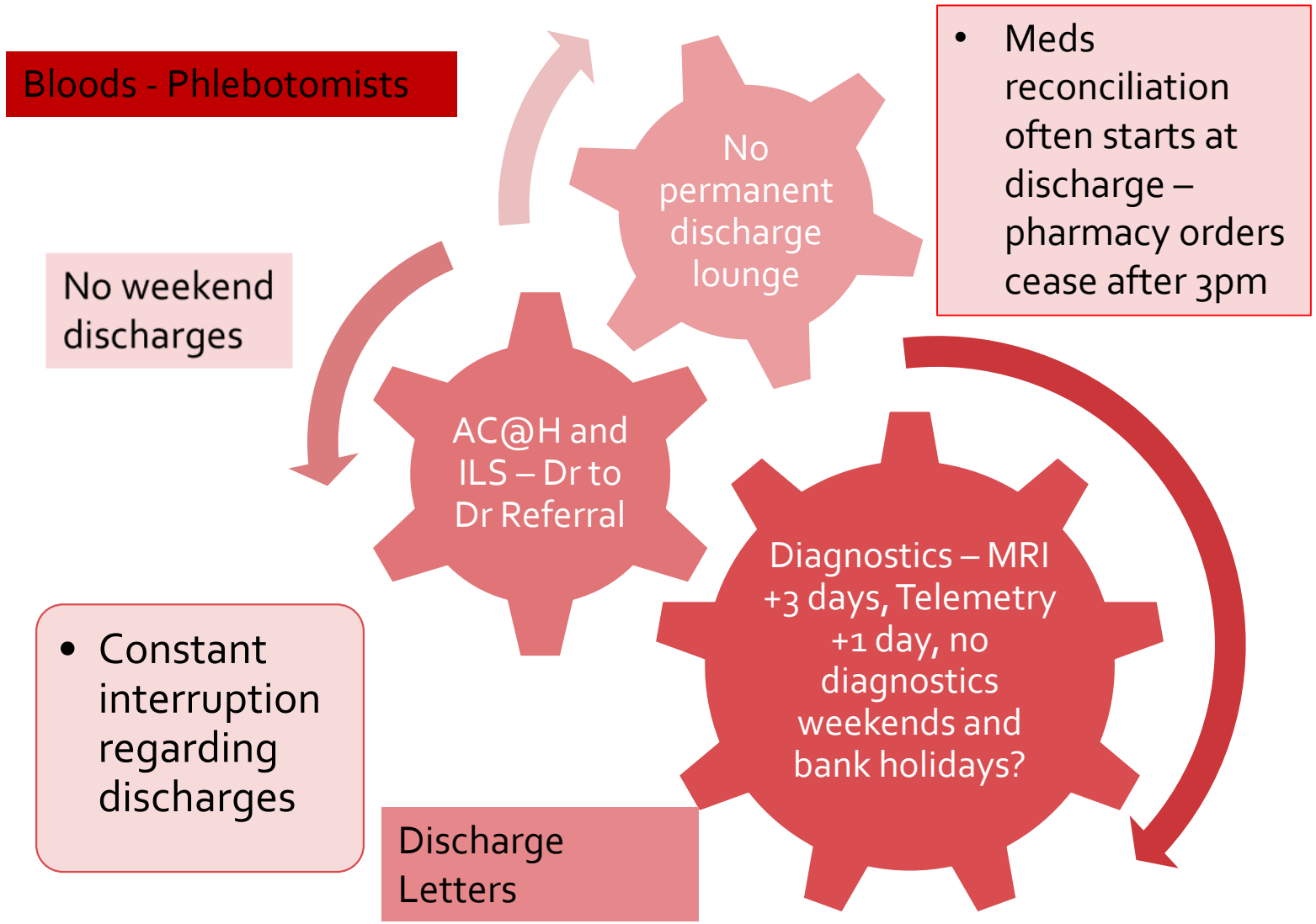
Current Ward Rounds



Current Board Rounds

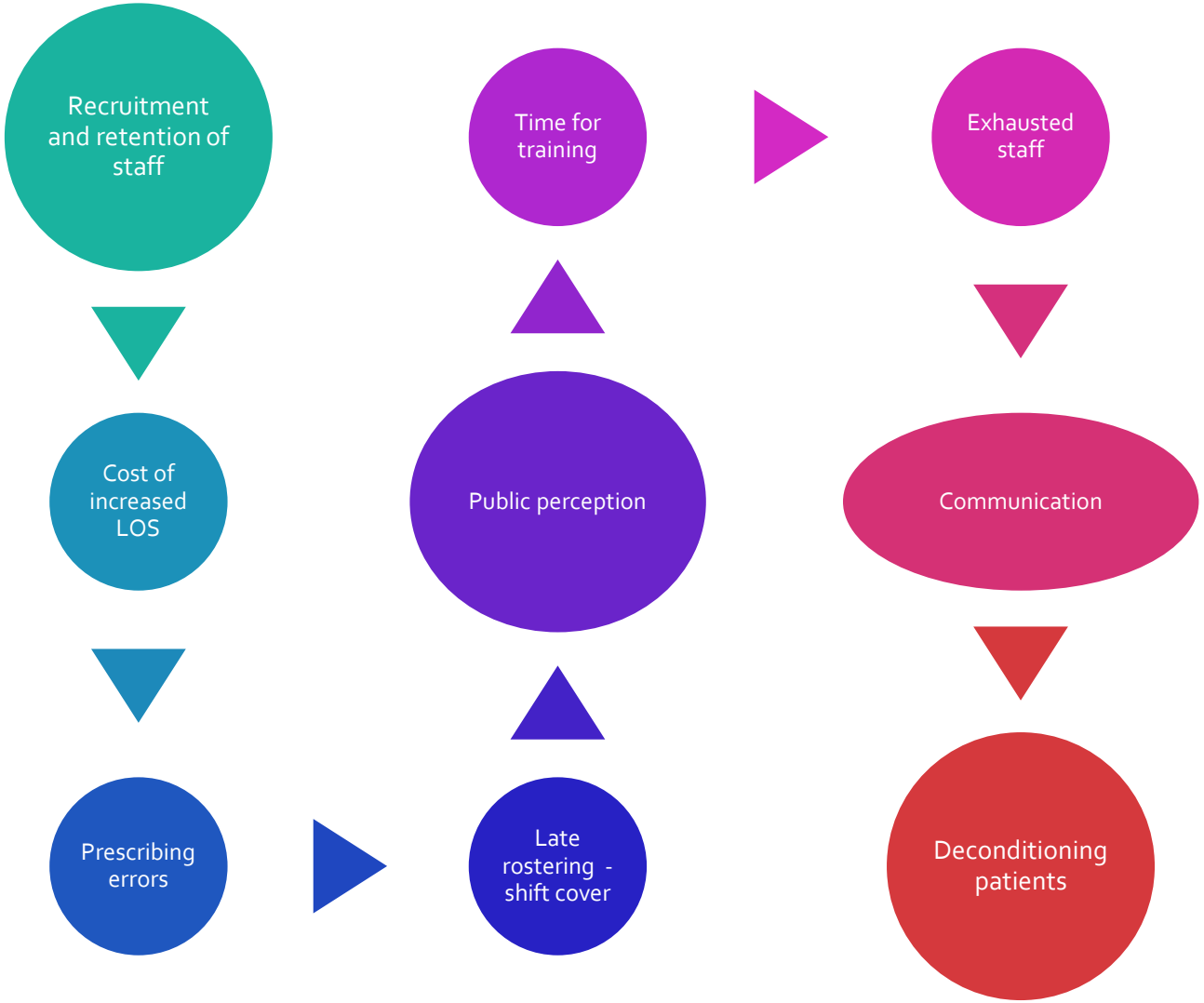


Delays in Patient Journey Impacting on LOS



How Do Staff Feel?

Are There Any Risks?



Staff Suggestions for Improvement

1. Stronger integration with ICS
2. Physician Assistants on all wards
3. Longer Pharmacy Opening Hours
4. Pharmacist for each ward
5. Permanent Discharge Lounge with a 'portfolio' e.g. catheter removal – to get patients out of the ward quickly and relieve pressure on nurses
6. Nurse led ward for complex patients awaiting discharge – don't need to be part of the 'ward round'
7. Consistent Social Worker for each ward
8. Review nursing staffing levels for evenings and nights

Staff suggestions continued

9. Create a team to complete timely MCAs

10. RED – GREEN – consistent training on use – all patients delayed on their pathway – not just discharges

11. Whiteboard meetings need to be MDT including medical and pharmacy staff

12. Phlebotomists

13. Ward Rounds need to include nurses and pharmacists

14. Whiteboard meetings need to be held earlier in the day

15. Rehab support is needed in the community

16. Escalation process for discharges instead of micromanagement

Staff Suggestions Continued

17. Alternative to extra beds on wards – lack of cubicle, locker and curtain stressful for patients and staff

18. Bed flips need to be minimised – very disruptive for staff and patients

19. Locums need clinics – many patients stay longer as Dr wants full diagnostics before discharging as no clinic to review

20. MRI?

21. Extended diagnostic service including cardiology, weekends and bank holidays

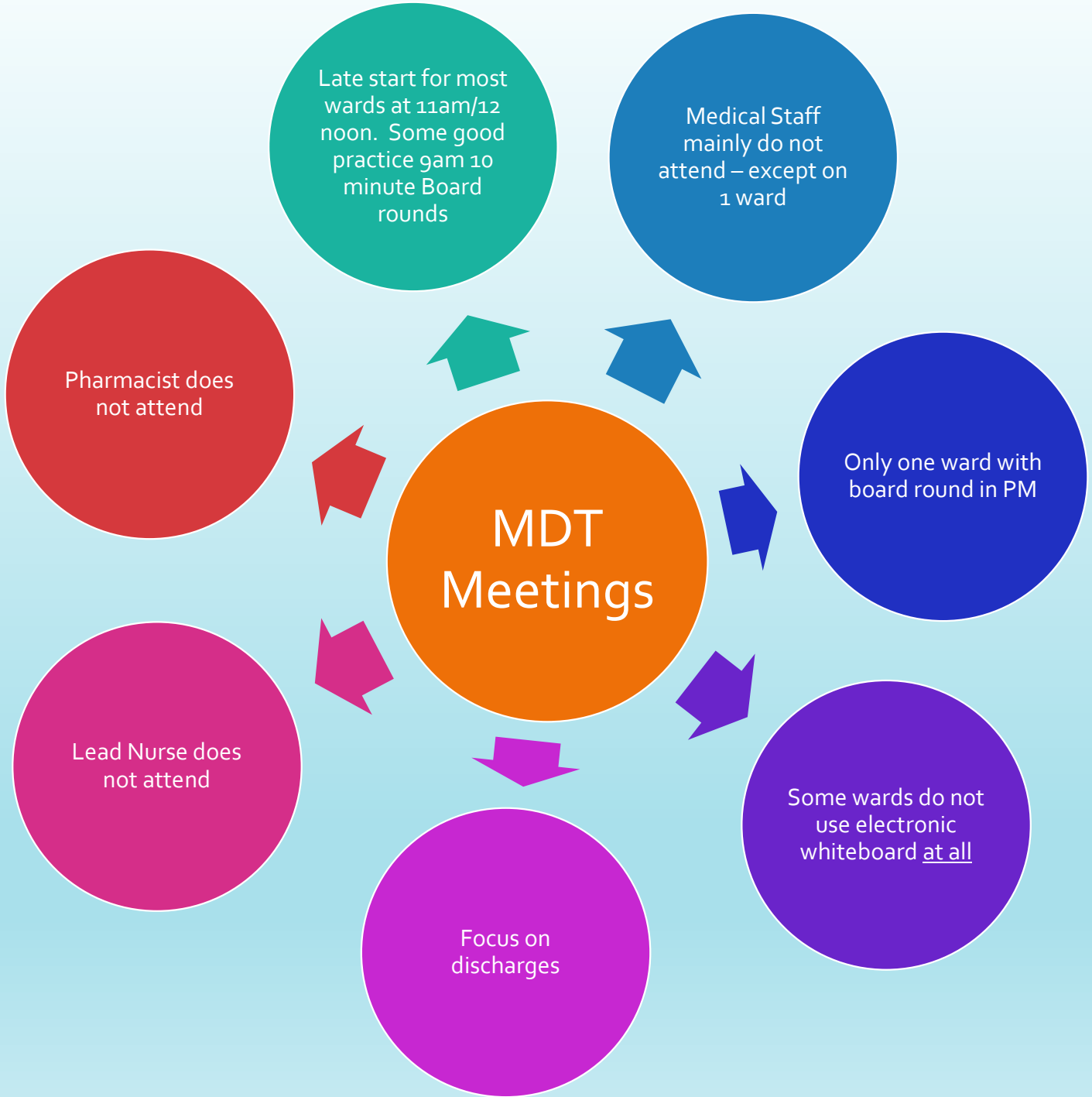
22. Process for PAs and Pharmacists to prepare discharges before medically fit for discharge readiness

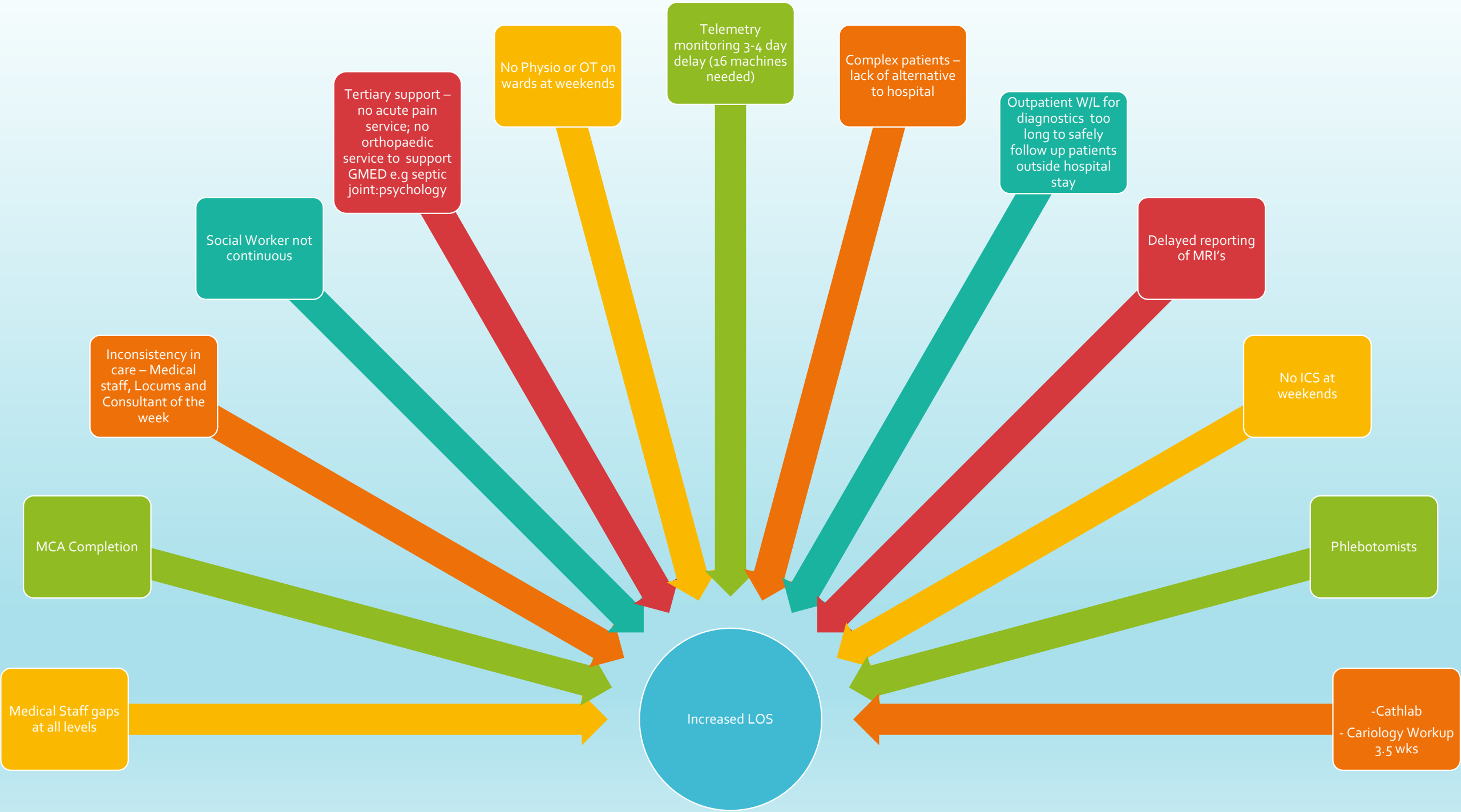
23. Nurse led discharge

24. Weekend Medical Handover focuses on sick and risk, no discharge planning, e.g if CPR below 130 patient could go home – change this

Ward Discovery Phase
Craigavon Area Hospital


Ward Rounds
Ward rounds Mainly Every Other Day with some exceptions were there is a daily ward round Mon- Fri
Uncommissioned wards – no standard/routine to ward rounds
Most ward rounds include nurses but not all
Not every ward has a whiteboard meeting
No weekend ward rounds. Limited discharge planning for weekends except Cardiology and Respiratory wards
Varied availability of Physicians Assistants. Where available, extremely valued
Wardrounds mainly in sequence – not sick & quick. All patients seen including those medically fit
Pharmacist does not attend ward round
No FY1's for uncommissioned wards – late discharges


MDT Meetings
Late start for most wards at 11am/12 noon. Some good practice 9am 10 minute Board rounds
Medical Staff mainly do not attend – except on 1 ward
Only one ward with board round in PM
Some wards do not use electronic whiteboard at all
Focus on discharges
Lead Nurse does not attend
Pharmacist does not attend


Increased LOS
Medical Staff gaps at all levels
MCA Completion
Inconsistency in care – Medical staff, Locums and Consultant of the week
Social Worker not continuous
Tertiary support – no acute pain service; no orthopaedic service to support GMED e.g septic joint:psychology
No Physio or OT on wards at weekends
Telemetry monitoring 3-4 day delay (16 machines needed)
Complex patients – lack of alternative to hospital
Outpatient W/L for diagnostics too long to safely follow up patients outside hospital stay
Delayed reporting of MRI's
No ICS at weekends
Phlebotomists
-Cathlab
- Cariology Workup 3.5 wks


Risk
Safety of Patients
Recruitment
Retention of staff
Over prescription of care packages
- deconditioned patients
No OT assessment area in hospital
No weekend ward round.
No treatment rooms on wards
Uncommissioned wards – 100% discharges have prescribing issues whilst in ward – no meds reconciliation on admission
Uncommissioned wards – only 4 permanent staff – all others temp
No Staff training days
Patients in corridors


Frustrated
Kept in the dark
Undermined
Asked the same questions repeatedly by different people
How do you feel
Angry
Unsupported
Nobody is listening
Under Pressure
"golden patients"
"4 discharges a day target"
No focus on quality

Suggestions

- Not clear on lead nurse role – should be at whiteboard meeting, expediting
- Expediter role – focuses only on discharges – should expedite all delays
- Accept daily red to green list as accurate
- Focus on discharge planning on Friday to highlight to weekend team
- Use the whiteboards to see green banner for those ready for discharge
- Should be Ward rounds at weekend or a dedicated MDT discharge team
- Another Cath Lab is required
- 16 more telemetry machines required

- Resolve Dentistry politics re: Cardiology work up
- Time for staff training & development
- More staff grade Doctors
- More Phlebotomists
- More Pharmacists
- Minimum aim for all planned bloods to be back before 1pm to aide decision making
- A set template and structure for whiteboard meetings – must be medically attended
- A second focused whiteboard meeting in the afternoon
- Preparation of discharge letters shared by all to enable FY1 to get to ward rounds

- Stable staffing
- Ward identity
- PA per ward
- Use whiteboards as the view of the truth
- Rehab in community

Observer Recommendations

Discovery Phase – Daisy Hill Hospital

Ward Rounds and Board Rounds (RCP Guidance on conduct of ward rounds 'Modern Ward Rounds')

1. Standardise Ward Rounds to improve communication and efficiency
   - Agree Timing ideally all patients seen by 12 noon
   - MDT (including pharmacy)
   - Agree frequency – ideally twice daily
2. Standardise whiteboard meetings
   - Agree timing – as early in the day as possible
   - MDT (including pharmacy)
   - Frequency (recommended twice daily)
   - Agree 'script' e.g. SHOP – St George's London

Running a structured Board round (S.H.O.P)

Sick patients

Senior decision-maker to see patient NOW if deteriorating or overnight/un-reviewed admission

- Is there a clear diagnosis?
- Are any tests outstanding?
- Is there clarity on who is doing what next?
- Is there an adequate management plan?
- Is the PDD still appropriate?

Home patients

Today's and tomorrow's discharges

- Are all necessary arrangements in place – TTOs, care package, transport?
- Can any outstanding investigations be booked as OP appointments?
- What needs to happen to enable pre-noon discharges?
- Can your patient go to QMC's discharge lounge early?

Other patients

Review plans and revise (as necessary)

- Is your patient medically stable?
- Is there a PDD and active discharge plan?
- Are any tests or interventions outstanding (are they still appropriate)?
- Has your patient waited more than 24 hours for an internal service (has this been escalated?)
- Can TTOs be done?

Plan

1 **Incoming patients & outliers**

- How many beds do you have?
- Expected admissions?
- Outliers in other specialties?

2 **Weekend plans**

- Does every patient have a plan of care and management?
- Is the patient suitable for nurse-facilitated discharge?

Observer Recommend-ations continued

3. Mandate use of Flow Electronic Whiteboard with incentive – no daily meetings or calls if whiteboard up to date
4. Agree minimum data set – EDD, Discharge status, referral to speciality, medically fit
5. Weekend handover should include discharge planning – Royal College of Physicians Best Practice Principles: '*Friday ward rounds should be led by the senior staff, take longer and include clear, documented plans for the weekend'*
6. Maximise use of PAs and ward pharmacists to prepare letters in advance of discharge, i.e. before patient is medically fit

6. Review pharmacy and Diagnostic services available hours i.e. evenings, weekends and bank holidays

7. MRI?

Observers Recommend-ations continued

8. Employ enough Phlebotomists to do bloods early in the morning (i.e. breakfast time)
9. Ensure consistent Social Worker for Wards
10. RED – GREEN training required for consistency and should be for all patients, not just potential discharges
11. Locums – follow up clinic in job plan?
12. Nurse facilitated Discharge – particularly weekends
13. Develop and deliver a communication plan for all staff at all levels

Summary

1. Layering more data on wards without process re-engineering will not bring any value
2. There is a need for standard setting – 'How we do things' – ward rounds, board rounds
3. MDT teamworking and communication improvements
4. Recognise and Reward success
5. Make best use of resources at the right level – Phlebotomists, Pharmacists, Physicians Assistants
6. Morning MDT board meeting and Afternoon MDT board meeting (including medical staff) will significantly improve flow
7. Set a script for the board meetings

Morning Board Round: Check List

	Action to complete
Introduction	• Hospital big picture (including Trust status) • Ward discharges • Patients TCI specific to program (DTAs, outliers, electives)
For each patient	**A: Clinical update** • Identify sick (e.g.: NEWS > 5, patients deteriorated overnight) • Safe bundle • Summarise medical/nursing/therapy plans, and actions agreed by MDT • Provide challenge and assign owners to escalate any delays (e.g. diagnostics) **B: Discharge planning** • Ensure EDDs are set at admission, and checked daily • Identify patients who are medically optimised and provide challenge for outstanding tasks • Summarise and document discharge criteria (location, actions required, timeline) with next steps and owner • Is this patient a discharge for today or tomorrow? - Identify actions required, with timeline and owners - Check patient suitability for criteria led discharge? - Check patient suitability for community support - Is discharge letter prepared
Summary	1. patients to see as a priority 2. Summary of number of discharges for today and tomorrow 3. Review of actions required for discharges with priorities based on timelines - Is there an owner assigned to every action? - Are there any actions that require escalation? If so, who will do this? - Does every action have a timeframe within which to complete? • Safety issues (including Duty of Candour) Key messages for families

Afternoon Board Round: Checklist

	Action to complete
Introduction	• Hospital 'big picture' update • Total queries and definite discharges identified in the morning
For each patient	Have the actions identified this morning been completed? • If not, why haven't they been completed? • Is this patient now ready to go? Do any actions require escalation at Flow meetings? • Are there any discharge dependent tasks? Are there any patients suitable for discharge tomorrow? • If so, can any of them be golden patients?
Summary	• Number of discharges for today and tomorrow